

TRANSACTIONS

OF THE

NEW YORK SURGICAL SOCIETY.

Stated Meeting, March 14, 1906.

The President, DR. GEORGE WOOLSEY, in the Chair.

STAPHYLOCOCCUS BONE INFECTION.

DR. CHARLES N. DOWD presented a boy, 9 years old, who when he came under Dr. Dowd's care in April, 1903, complained of spasm and tenderness in both hip-joints. The chief point of interest in his previous history was that he had had abscesses above the ankle and also in the forearm.

The case developed all the symptoms of ordinary hip-joint disease. An abscess formed in the left thigh, which was aspirated, and following this the function of the hip-joint was restored. Subsequently, another abscess developed in the vicinity of the right hip-joint; this was also opened and drained. There were a number of recurrences, and the patient was sent to the country. In October, 1904, there was involvement of the left humerus; an abscess developed which led down to the epiphysis, and necessitated removal of the interior of the upper end of the bone. There were recurrent abscesses in the right thigh, and recently a large abscess in the back. On cutting down upon it, a large amount of pus was evacuated which contained a pure culture of staphylococcus pyogenes aureus.

The X-ray findings of the patient showed the difference from tuberculosis much more than the clinical history did. A picture which was taken a year and a-half ago showed extensive involucrum formation about the upper part of the shaft and the neck of the right femur, and considerable similar formation about

the neck of the left femur, whereas the joint itself did not look like a tubercular joint. This involucrum deposit had been steadily diminishing ever since, and at the present time was much less marked than it had been, and at the present rate the bone would soon resume its normal size and shape. The motion in the left hip at the present time is normal; that in the right hip is moderately restricted. The motion in the left shoulder-joint is normal

Dr. Dowd referred to other similar cases which he had seen and to an article on the subject of staphylococcic disease of the hip-joint by Von Bruns, which describes more than one hundred cases of osteomyelitis affecting the hip which had been observed in the Tübingen clinic. These cases are apparently usually considered to be tubercular.

A second patient, shown by Dr. Dowd, was a young man of 17, with a bone abscess in the interior of the left tibia, which had never broken through the surface, and from which the patient had had symptoms for several years. When he first saw the patient, a year ago, there was a hard swelling of the tibia about four inches below the knee, with moderate tenderness on pressure. The patient had for the previous nine years had pain in this locality. At the onset he was confined to bed for two or three weeks and during a portion of each year, usually in the spring, he would also be confined to bed for a few days, and during the rest of the year he was unable to go about as other boys did and usually felt some tenderness in his leg. He habitually wore a protective bandage, and had to abstain from the ordinary games of boyhood. An X-ray picture taken at that time showed thickening of the bone about the cortex of the tibia, and a clearer place within, which was diagnosticated as an abscess. Several pictures were taken and all showed the same condition. No operation was permitted for another year, but about a month previously, on cutting into the tibia, the abscess was found; It was about as large as a large hickory-nut and contained soft purulent material, from which pure cultures of staphylococcus pyogenes aureus grew. The cortex of the bone was very hard, and at least half an inch of hard bone had to be chiseled through before the abscess was reached. The very slow course of the staphylococcus infection in both of these cases seemed worthy of note.

DR. FREDERICK KAMMERER presented a woman, 41 years old, who first came under his care in July, 1895. Her history dated back for two years, and consisted essentially of frequent attacks of renal colic on both sides. On the right side she had a large tumor corresponding with the site of the right kidney. The urine was filled with pus, and the woman was in a septic condition.

On July 10, 1895, Dr. Kammerer exposed and incised the right kidney, and evacuated a large amount of pus. In the pelvis of the organ a large calculus was found, which could only be removed by breaking it up. The patient's condition was such that a nephrectomy was deemed inadvisable. The kidney was therefore drained, and about two months later, after an unsuccessful attempt to induce the fistula to close, the kidney was removed. The wound thereupon healed kindly. The urine still contained a small amount of pus, but there was no further pain on that side.

On February 21, 1897, the patient was suddenly seized with a pain in the left side. For several days her temperature ranged about 103, with very scanty urine, and severe pain over the left kidney. On February 21 she passed about 200 c.c. of urine. On the following day a still smaller quantity was voided, and on February 23, at 5 A.M. complete anuria set in. After fifteen hours had elapsed, Dr. Kammerer cut down on the kidney. He found the pelvis of the organ, as well as the ureter, much distended. He incised the latter about one inch from its junction to the pelvis, and evacuated a quantity of purulent urine; then, on inserting the finger, he found three small stones in the pelvis of the kidney, which he removed. With a probe he also made out a calculus in the ureter, about four inches from the junction of the ureter with the pelvis, and after freeing the former from the surrounding tissues he was able to push the stone up into the incision and extract it. Drainage of the kidney was resorted to through an incision into the substance of the organ, and for several weeks the course of the case gave rise to some anxiety. On the fifth day the packing was removed, and five catgut stitches were inserted to close the incision into the ureter. There was still slight leakage at that point, but in the course of a month, both the incisions into the ureter and the kidney tissue had closed, and the further recovery of the patient was uneventful.

Eight years had elapsed since the second operation, and the patient still remained in excellent health. With the exception of a few pus corpuscles, the urine was quite free, and her pain had entirely disappeared.

In a second case of renal calculus, which was reported by Dr. Kammerer, the patient was a musician, 42 years old, who came under his observation last summer. He gave a history of severe and frequent attacks of renal colic, dating back for two years, with pus and blood in the urine. His symptoms were easily referred to the right side.

When Dr. Kammerer first saw the patient, on June 25, 1905, the man's temperature had ranged between 103 and 104 for several weeks. The urine contained a large amount of pus, and the enlarged right kidney was distinctly palpable. Upon exposing it, and during an attempt made to free it, the kidney ruptured at its convexity, and a large amount of purulent urine escaped. No stones were found in the kidney or pelvis, but on introducing a probe into the ureter, a calculus was located at a depth of about eight inches from the rent of the kidney. On account of the patient's condition, no attempt was made to dislodge it at the time, but two weeks later, through the usual incision around the crest of the ilium, the ureter very much distended was laid bare and incised, and the calculus extracted. The incision in the ureter was immediately sutured, and the kidney was drained. The patient made a slow but satisfactory recovery, and finally the wounds closed without the necessity arising for a nephrectomy, which it had been feared would be the case.

About six weeks after the operation, the patient was suddenly seized with chills, his temperature rose to 105, and he complained of pain over the left kidney. The organ rapidly enlarged, and the patient's condition became very alarming. High fever, dry tongue, delirium, etc. When the left kidney was finally exposed, it was found to be twice its normal size. Upon incising it, a large amount of purulent urine was evacuated. No stone was found in either the kidney or its pelvis, but, as on the opposite side, and at about the same distance, an obstruction was discovered in the ureter. The patient was in a condition of profound sepsis, and no attempt was made to further determine the nature of the obstruction. On the day after the operation

he passed a small stone spontaneously, which had apparently been located at the time of the operation in the ureter perhaps pushed down towards the bladder. For two weeks the patient's condition was very serious; then he began to improve, and had since remained in excellent health.

The cause of the infection of the second kidney in this case, Dr. Kammerer said, was rather obscure. The symptoms developed about six weeks after the first operation, when the patient was up and about. He had never been catheterized.

In both of these cases, Dr. Kammerer said, he followed the method of securing a satisfactory exposure of the kidney by doing a preliminary resection of the twelfth rib.

POSTOPERATIVE COMFORT.

DR. WILLIAM G. LE BOUTILLIER read a paper with the above title (for which see Page 106).

DR. ANDREW J. MCCOSH said that Dr. Le Boutillier might have done well to extend his timely and interesting paper so as to cover the preoperative stage, which included the repeated enemas, the scrubbing and shaving, which many patients dreaded more than the operation itself. While this preoperative treatment was not as severe as it was a few years ago, its machine-like routine was still open to much improvement.

The speaker said he was thoroughly in accord with Dr. Le Boutillier's advocacy of giving the patients plenty of fluids by rectum, and personally he had found that frequent enemas and irrigations with Kemp's tube were very satisfactory, especially in the severe abdominal cases where there was much thirst.

Dr. McCosh said that in his opinion, the postoperative comfort of the patient could be considerably enhanced by certain modifications on the operating table. For example, the insertion of *tight* sutures, embracing a good deal of the skin, and forming the so-called step-ladder cicatrix, frequently gave rise to much pain. There was no reason for embracing such a wide area of tissue, nor pulling the stitches so tightly.

In regard to postoperative feeding, Dr. McCosh said he would not resort to it quite as early as was advocated by the reader of the paper. A few days' starvation was usually not such a great hardship, providing fluids were not withheld. Too early

feeding was apt to give rise to colic and the formation of gases. The less food that was given during the first two or three days, the better. The albumen orangeade and lemonades which were so much employed by nurses, he thought often gave rise to colic pains and abdominal discomfort.

DR. GEORGE WOOLSEY said he had found that position made a great difference in the postoperative comfort of the patient, and with that object in view he frequently ordered the Fowler position, especially in stout patients, although it was not originally intended for that purpose. In a recent case of abdominal hysterectomy the foot of the bed had been elevated with considerable discomfort to the patient. He had the blocks removed from the foot of the bed, and the patient felt so much more comfortable that she herself suggested that the head of the bed be raised.

GANGRENE OF THE LEG IN A CHILD.

DR. GEORGE WOOLSEY presented a specimen removed from a child, twenty-six months old. Nine months ago there was a history of an attack of measles, with apparent recovery. About a month ago there was a sudden onset of fever, cough and prostration, which was first regarded as a bronchitis and then as pneumonia. Without any distinct crisis, there was improvement on the seventh day. Two days later, the right leg became blanched and quite cold, and on the fifth day thereafter the color changed to a bluish-black. On the seventeenth day of the disease, when Dr. Woolsey first saw the child, the respirations ranged between 45 and 60; there was some cough, with signs of consolidation in the left lower lobe, and the patient's general condition was not good. The temperature was elevated at night; there were no sweats. The gangrene of the right leg extended to just below the knee; the toes were shriveled; there was a well-marked stationary line of demarcation. Four days later the patient was removed to the Presbyterian Hospital and Dr. W. P. Northrup, who examined the patient on that day, still detected signs of unresolved pneumonia in the left lower lobe.

Five days later, as the gangrenous area was beginning to separate an immediate operation was advised, and because of the fact that the gangrene extended so close to the knee, the amputation was done just above that joint. The cause of the gangrene

proved to be a thrombus of both tibial arteries, extending up into the popliteal for $\frac{1}{4}$ inch, and the vein was also more or less thrombosed. The operation was done three days ago, and the case was apparently progressing favorably.

The patient was also seen by Drs. A. Jacobi and Henry Koplik, neither of whom had ever seen this complication occur in a child in the course of pneumonia. Dr. Jacobi had seen it after measles, and it is not uncommon in adults after typhoid fever, and is sometimes seen in them after pneumonia.

RENAL CALCULI.

DR. GEORGE WOOLSEY presented specimens removed from a woman, 42 years old, whose family history was negative. There was no venereal history. She had been a resident of the United States for seventeen years, and was the mother of seven children, all living, and had two miscarriages. After the second of these, she was curetted. Her last child was born four years ago.

Her present trouble began about six years ago with frequently recurring attacks of dragging pain on the right side of the abdomen; this was never very sharp, and did not radiate either up or down. It was relieved by rest. There was no history of vomiting.

Examination of the urine showed a marked trace of albumin, with considerable pus (about one-half of one per cent. in bulk), and a few red blood-cells. There were no casts. The blood count was normal. No tubercle bacilli were found in the urine. There was no frequency of micturition. An X-ray was taken, but the plates were poor and showed nothing.

On examination, the right kidney was readily palpated, and freely movable. It was enlarged, but not nodular. Through a lumbar incision the organ was exposed and incised along the outer border, and three calculi were found and extracted. Two of these, originally one which had been split in two, had rested in perfect apposition, and by attrition their opposed surfaces had been worn smooth. One had projected down into the ureter. There was slight infection of the kidney, but its lower half seemed to be entirely normal, and the kidney was therefore drained and not removed. The patient was making an uneventful recovery.